How pregnancy can be made more difficult by maternity care's notions of 'normal'

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Credit: Pavel Danilyuk from Pexels

Maternity records in the UK have spaces only for the expectant mother and the baby's father. This inflexibility can cause difficulties for the pregnant person, their partner, and their unborn baby if they do not fit

into these boxes.

Over the last decade there has been a significant increase in the number of people conceiving outside of the traditional model of a heterosexual couple, so this affects an increasing number of parents. It's not known exactly how many lesbian women give birth, but fertility treatment in UK clinics for lesbian couples has increased 15-20% year-on-year for the past decade. In 2016 there were 1,404 live births registered to same-sex female couples.

No data is available for the numbers of trans men (that is, female-to-male transgender people) who give birth in the UK. But some trans men choose to do so, and the number of referrals to gender identity clinics is rising each year.

Research shows that problems occur when heteronormativity—the perception that heterosexuality is the normal, default, or preferred sexual orientation—is communicated either overtly or subtly in the way healthcare staff treat patients, the way leaflets are worded, or the assumptions made in the way administration systems are designed.

This means that co-mothers (the non-birth mothers in lesbian families) may not be recognised as parents, and so miss out on support such as breastfeeding advice for example, and it can leave both pregnant trans men and lesbian co-mothers feeling excluded.

Poor experiences in the run-up to, during and after birth can negatively affect expecting couples emotionally and psychologically in ways that lead to problems for the whole family, including the baby. For example, postnatal depression is common and associated with adverse outcomes for both mother and child. A number of studies, while small scale and qualitative in nature, point to higher incidence of symptoms of postnatal depression among lesbian birth mothers. There are also similarly small

scale and qualitative studies that suggest similarly heightened feelings of anxiety and depression among lesbian co-mothers.

For co-mothers in particular, this seems linked to their sense of connection with the baby, and from the extent to which they feel recognised as a parent or not by maternity services, family and friends and wider society. The combined stress of identifying oneself as lesbian or bisexual to healthcare staff, and the attitudes of wider society, alongside the stress of pregnancy generally are greater than that experienced by heterosexual pregnant women, and represent a plausible reason for higher symptoms of postnatal depression among lesbians.

This wider issue of difficulties experienced due to heteronormativity in maternity services is something research suggests exists worldwide.

Discrimination and danger

For a decade I have worked as a doula, offering non-clinical care and support to women during their pregnancy, through labour and birth and in the days and weeks afterwards. In my experience issues have often arisen among those who do not fit the configuration of a heterosexual couple.

Earlier this year, I cared for a pregnant trans man whose unborn baby had a 50:50 chance of having a life-threatening medical condition, and might have needed blood transfusions while still in the womb. The condition can be tested for through a maternal blood sample, which his midwives requested. But the laboratory repeatedly failed to do the right test on the blood sample, assuming that the forms had been mixed up because a maternal test was requested for a patient whose records stated was male. This caused weeks of delay, at a time when, for the baby's health, every day counted.

In a case from the US, a pregnant trans man who attended hospital with severe stomach pain was not treated urgently, after it was initially assumed he was obese rather than pregnant. As a result, doctors missed that his baby's umbilical cord had slipped through the cervix before the baby—a rare but serious birth complication that requires an immediate birth by caesarean—and the baby subsequently died.

It is sometimes not patient records or administration systems but individual staff whose heterosexist assumptions mean birth partners are treated differently. For example, it is common for partners to be allowed longer visiting hours on postnatal wards, and encouraged to fetch food from the canteen for their partners. But lesbian partners may be denied access to wards or not allowed to assist their partners because staff assume all partners are male, and that women trying to come into a postnatal ward are merely other visitors.

They may also encounter blatant homophobia or transphobia from those caring for them, such as the midwife who told a new mum that it was "disgusting" that her baby had two mums. Discrimination may be illegal, but there is evidence that covert, harder-to-prove prejudicial treatment continues, including the doctor who found inventive ways not to offer fertility treatment to a lesbian by trying to frighten her, and then by not responding to her queries or passing on her test results. Or the midwife who showed her disapproval of lesbian mums by performing rough vaginal examinations on a woman in labour.

It is more common however that healthcare staff are well-intentioned but lack the skills, confidence and training to provide good care to pregnant lesbians and trans men. The Royal College of Nursing and birth support charity NCT have highlighted the issue, but midwives say that while treating lesbian birth mothers is part of their job, they don't always know how to treat the co-mother. Some say colleagues struggle to care for pregnant lesbians due to their religious beliefs.

Better data will reveal the reality

In the UK, NHS Trusts do not yet collect data on the gender or sexual orientation of pregnant people and their partners. Because we don't have this data, we don't have much information about the statistics for lesbian and trans men's pregnancy outcomes or birth experiences. Most pregnancy and birth research and most laws and regulations assume babies are created in a heterosexual relationship.

There is no simple solution—substituting "pregnant people" for "pregnant women", or "partners" for "fathers" on documents may lead to invisibility (especially of women), confusion about whether genetic or social information is required, and is a sticking plaster that doesn't solve the difficulties they face. We need to understand the problem better: the physical and mental health needs of pregnant lesbians and trans men are hugely under-studied, and so poorly understood.

A good start would be for NHS maternity records to properly record the gender and sexual orientation of pregnant people and their partners in order that we can more accurately know the number of lesbians and trans men giving birth in Britain, and begin to understand how their experiences may be similar or different to heterosexual women's birth experiences.

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